Beautiful Mind Therapy, Inc
Phone: 708-695-4808 Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

Authorization for Release of Medical Information

Patient Name: Date of Birth:

Address:

City: State: Zip Code: Phone:

I authorize the release of my health information from Beautiful Mind Therapy ("BMT") to:

Individual or Organization's Name:

Address:

City: State: Zip Code: Phone:

Purpose of Information Release:
☐ Further Treatment/Continued Care ☐ Personal Use ☐ Attorney/Client ☐ Insurance
☐ Other (specify) ____

Requested Delivery Date ______________________

Medical Records Requested For Dates of Service: From_______________ To _________________
(If no dates listed, records will include the past 24 months)

Method of Delivery: ☐ Fax Number: ____________________________

☐ Mailing Address:
City: State: Zip Code: Phone:

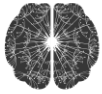
I authorize the release of the following health information:
☐ Treatment Plan ☐ Intake Assessment ☐ Progress Notes ☐ Discharge summary ☐ All Documentation

I understand that BMT has up to 30 days to review and respond to requests. I understand that BMT authorized to receive or exchange this information has the right to inspect and copy the information to be disclosed. I further understand that if the entity receiving this information is not a healthcare provider covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by privacy laws. BMT is not accountable or responsible for such re-disclosures. Also, Federal Confidentiality Rules, 42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that if I do not sign this authorization, BMT may not deny me care based on my unwillingness to sign this form; however, BMT may refuse to provide care to me if the care is being provided solely for the purpose of collecting health information to be released to a third party (for example, pre-employment examination, court purposes, DCFS matters, anger management mandated treatment, workers compensation cases).

I understand that I may revoke this consent at any time providing a written revocation to BMT. Your revocation will only apply to disclosures that have not already occurred. This consent will expire 6 months after the date of client termination unless another date is specified. For reimbursement purposes, this authorization shall remain in effect until full reimbursement for services has been received by BMT.

I understand that I have the right to inspect and copy the mental health and developmental disabilities records that will be released.



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It is my full understanding that the records and communication to be disclosed will include sensitive information such as evaluation, diagnosis, treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, or HIV/AIDS unless specifically initialed by the client for exclusion.

I understand that I will be charged the following fees to obtain my records: $1.11 per page (pages 1 through 25), $0.74 per page (pages 26 through 50), $0.37 (pages 50 and more) plus a handling charge of $29.48.

By signing below, I agree to the statements in this authorization form.

• Patients 12–17 years of age must sign for mental health and developmental disability, substance abuse/alcohol treatment, pregnancy, sexual assault, or birth control information.
• Witness/Signature is required for any mental health and developmental disability information.
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Patient Name: ______________________________ Patient Signature: __________________________________ Date: ______________________
(age 18 and older)

Patient Name: _____________________________ Patient Signature: __________________________________ Date: ______________________
(age 12 – 17)

Parent/Guardian name:_______________________ Patient Signature: __________________________________ Date: ______________________
(for client under age of 18)

Witness Name: _____________________________ Witness Signature: ________________________________ Date: ______________________